

HEALTHCHECK SERVICES, INC.

72 Fern Park Lane • Dawsonville, GA 30534 770•888•8988

VACCINE INFORMED CONSENT:

(Date and time: November 17, 2011 from 11:30a.m. - 1:00 p.m. outside MS/HS Infirmary)

Flu Shot_____ \$23.00

Flu Mist_____ \$25.00

Please make checks payable to HealthCheck Services

Name _____ Daytime Phone _____

Address _____ DOB _____ Sex: M F

City _____ State _____ Zip _____

1. Are you allergic to eggs? Yes No
2. Do you have any problems with your immune system? Yes No
3. Did your doctor tell you that you had asthma or reactive airway disease? Yes No
(If yes, you are not eligible to receive the Flu Mist)
4. Are you pregnant or nursing? Yes No
5. Do you currently have a cold, fever, or other respiratory illness? Yes No
6. Have you recently received any vaccinations or allergy shots (1 week) ? Yes No
7. Are you taking any prescription meds to treat the flu? Yes No
8. Do you live with someone who has a compromised immune system
or is less than 6 months of age?
(If yes, you are not eligible to receive the Flu Mist) Yes No
9. Is this the first time you have ever had a flu vaccine? Yes No

As with any medicine, there are very small risks that serious problems could occur after receiving this vaccine. However, severe reactions are rare and pose much less risk than the risks from the disease. Possible side effects associated with the vaccine that you experience are runny nose/nasal congestion, headache, cough, sore throat, tiredness/weakness, irritability, and muscle aches. These symptoms usually begin 6 to 12 hours after receiving the vaccination and can persist for 1 to 2 days.

I have read or have had explained to me the information above about the flu vaccine and truthfully answered all the questions on this form. I have had a chance to ask questions which were answered to my satisfaction. As with other vaccines, vaccination does not guarantee 100% effectiveness. I believe I understand the benefits and risks of the vaccine and request that it be administered to me or to the person named below for whom I am authorized to sign. Neither HealthCheck Services nor Wesleyan School shall at any time or to any extent whatsoever be liable, responsible, or in any way accountable for any loss, injury, death or damage suffered in connection with or as a result of this vaccine program or the administration of the vaccine described above.

Signature/parent _____ Date _____

Site: L Arm R Arm Manu: _____ Lot: _____